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Notice of Independent Review Decision

May 13, 2014

IRO CASE #:

DESCRIPTION OF THE SERVICE OR SERVICES IN DISPUTE:
Laminotomy with decompression, nerve root and lumbar additional vertebral space and lumbar laminectomy additional segment

A DESCRIPTION OF THE QUALIFICATIONS FOR EACH PHYSICIAN OR OTHER HEALTH CARE PROVIDER WHO REVIEWED THE DECISION:
Orthopedic Physician

REVIEW OUTCOME:

Upon independent review, the reviewer finds that the previous adverse determination/adverse determinations should be:

☒ Upheld (Agree)

Medical documentation **does not support** the medical necessity of the health care services in dispute.

Provide a description of the review outcome that clearly states whether medical necessity exists for each of the health care services in dispute.

INFORMATION PROVIDED TO THE IRO FOR REVIEW:

PATIENT CLINICAL HISTORY [SUMMARY]:
The patient is a female who was injured at work on xx/xx/xx, when she fell from a chair landing onto her back. She had an onset of low back pain with radiation to the bilateral lower extremities with numbness and tingling.

2012: On November 15, 2012, a lumbar spine magnetic resonance imaging (MRI) performed showed: (1) At L3-L4, there was a 3 mm central L3-L4 disc herniation with compression of the anterior thecal sac and slight narrowing of the right and left L3-L4 intervertebral foramen. (2) At L4-L5, there was desiccation and loss of normal water content without ventral defect or disc herniation or bony spinal stenosis. (3) At L5-S1, there was central and left L5-S1 disc herniation with

compression of the left anterior and lateral thecal sac and left L5-S1 intervertebral foramen. There was a question of laminectomy defect at the L5-S1 level. There was no abnormal gadolinium enhancement. The study was requested for low back pain down both legs. There was also mention of a xxxx work injury.

2013: On January 15, 2013, a lumbar myelogram showed faint indentations on the thecal sac at the L3-L4 and L4-L5 levels with a moderate indentation on the thecal sac at the L2-L3 level. The L5-S1 interspace was flattened. There was a slight retrolisthesis of the L4 relative to L5. A post myelogram computer tomography (CT) scan showed a 3-mm right paracentral disc protrusion that focally effaced the thecal sac. There was abutment of the right third lumbar nerve root at the level of the subarticular recess without diminished nerve root filling. At L3-L4, there was posterior endplate spur and a broad-based 4 mm central disc protrusion/herniation that effaced the ventral thecal sac without central spinal stenosis. At L4-L5, there was posterior endplate spurring or bulging and a superimposed tiny left paracentral disc protrusion resulting in effacement of the left ventral lateral aspect of the thecal sac without central spinal stenosis or neural foraminal stenosis. At L5-S1, there was moderate disc flattening present. There was prominent focal left para midline osteophyte formation measuring approximately 4 mm in AP dimension abutting and slightly elevating the left first sacral nerve root with slightly diminished nerve root filling on initial myelographic images. This nerve root did appear to fill adequately on delayed CT myelographic images. There was trace annular bulging present without neural encroachment.

On February 1, 2013, performed a caudal epidural steroid injection (ESI). Postoperative diagnoses were chronic low back pain, status post lumbar fusion and lumbar radiculopathy.

On March 19, 2013, evaluated the patient for low back pain. She rated the pain at 8/10. The patient also reported poor sleep pattern. She was overall doing the same from her last visit. The patient was currently utilizing hydrocodone, Ultram, Neurontin and Flexeril and reported that these were helpful with increased function and activities of daily activities (ADLs). The patient had fair pain control with current regimen. diagnosed displacement of lumbar intervertebral disc without myelopathy, lumbago, and thoracic or lumbosacral neuritis or radiculitis, unspecified. The patient was prescribed Opana, discontinued hydrocodone, recommended continuing Narcotic program and advancing to home exercise program (HEP). She was referred to an orthopedic surgeon.

On April 29, 2013, evaluated the patient for back and leg pain. noted that the patient had undergone a lumbar surgery in 2009 with improvement in her symptoms for approximately two years. The patient complained of constant low back pain radiating to bilateral lower extremities. She rated the pain at 9/10. It was exacerbated by standing or walking. She also had numbness and tingling in her legs and was able to walk for approximately ten feet. It was noted that the patient had multiple falls, had physical therapy for several months and three to four lumbar ESIs without relief. Her history was remarkable for hypertension, depression, lumbar spine surgery, cholecystectomy, appendectomy, Lap-Band

surgery and right ankle surgery. The patient was utilizing hydrochlorothiazide, Zoloft, gabapentin, hydrocodone, Tramadol, Clonazepam, cyclobenzaprine, Cymbalta, Ambien and Topiramate. On examination, motor strength was 4/5 in the bilateral iliopsoas, bilateral extensor hallucis longus/TA and left gastrocnemius/soleus. There was decreased sensation to light touch and pinprick in the bilateral L4-L5 and left sacroiliac (SI) distribution. Her gait was antalgic. She had difficulty in walking on her heels and toes and tandem walking. reviewed the CT/myelogram of the lumbosacral spine done in January 2013. diagnosed history of previous lumbar spine surgery with bilateral lumbosacral radiculopathy and neurogenic claudication. The patient was requested to obtain reports from her previous lumbar spine surgery.

On May 10, 2013, the patient continued with severe pain at 9/10 in intensity and was able to walk for approximately ten feet. opined that the patient would benefit from bilateral L3-L4 hemilaminotomy and foraminotomy and L5-S1 lumbar laminectomy, facetectomy, foraminotomy and fusion with transforaminal lumbar interbody fusion (TLIF) and instrumentation. She would also require fusion at L5-S1, as she would develop surgically induced instability after an L5-S1 discectomy and bilateral facetectomies to decompress the exiting L5 nerve roots. The patient decided to proceed and it was to be scheduled after approval.

On June 28, 2013, the patient indicated that her symptoms had markedly worsened and she was having decreased sensation in her legs. On examination, she had 4-/5 strength in the bilateral iliopsoas and bilaterally extensor hallucis longus (EHL)/TA and left gastrocnemius/soleus. Sensation was decreased to light touch and pinprick in the bilateral L4-L5 and left S1 distribution. Her gait was antalgic. recommended a repeat MRI of the lumbosacral spine.

On July 19, 2013, the patient stated she had fallen on xx/xx/xx, and had worsening of her leg pain and numbness. recommended repeat lumbosacral MRI.

On September 23, 2013, electromyography/nerve conduction velocity (EMG/NCV) study of the lower extremities showed findings indicative of a left L5 radiculopathy.

On October 14, 2013, the patient complained of low back pain radiating to bilateral lower extremities. recommended obtaining new MRI of the lumbosacral spine and new CT/myelogram for further evaluation. The patient was to follow up after the study.

On December 13, 2013, MRI of the lumbar spine showed following findings: (1) At L2-L3, a 2-3 mm right paracentral disc protrusion consistent with recent MRI findings that did not result in central canal stenosis. (2) At L3-L4, there was a 3 mm slightly left paracentral disc protrusion, overall unchanged from the comparison study, effacing the thecal sac without central canal stenosis or significant nerve root deviation. (3) At L4-L5, there was broad-based slightly left asymmetric disc bulge versus protrusion mildly effacing the left ventral thecal sac without central canal stenosis or neural foraminal stenosis. On post-contrast

images, there was enhancement in the midline and left para-midline annular margin consistent with epidural fibrosis related to partial discectomy at this level. (4) At L5-S1, there was broad-based central protrusion slightly asymmetrically pronounced to the left of the midline measuring 4 mm in AP dimension, not significantly changed from the appearance on recent myelogram.

2014: On January 17, 2014, the patient complained ongoing low back pain radiating to the bilateral lower extremities. reviewed the lumbosacral MRI dated December 13, 2013, and opined that L5-S1 disc protrusion causing lateral recess stenosis was likely producing the patient's symptoms. The patient was recommended to obtain operative report from previous lumbar spine surgery.

On January 24, 2014, the patient complained of worsening of low back pain radiating to the bilateral lower extremities and rated it at 9/10. On examination, the patient had 4/5 strength in the bilateral iliopsoas, EHL/TA and left gastrocnemius soleus. Sensation was decreased to light touch and pinprick in the bilateral L4 and L5 and S1 distribution. Gait was antalgic. opined that the patient would benefit from bilateral L5-S1 hemilaminotomy, foraminotomy and possible microdiscectomy. It was to be scheduled after approval.

Per utilization review dated February 12, 2014, the request for bilateral L5-S1 hemilaminotomy, foraminotomy and possible microdiscectomy was denied with the following rationale: *"The guidelines indicate laminectomy would be supported when there are findings of radiculopathy documented on physical examination and corroborated by imaging studies and/or electrodiagnostic testing. The physical examination indicated there was compromise of the L4-S1 nerve roots; however, electrodiagnostic studies indicated evidence of a left L5 radiculopathy only. The most recent lumbar MRI documented no central canal or neural foraminal stenosis. There was adequate nerve root filling of all levels on delayed imaging of the CT. The claimant failed to respond to physical therapy; however, the duration of the physical therapy was not documented. A home exercise program was not noted to have been tried to address the complaints. The request for a bilateral L5-S1 hemilaminectomy, foraminotomy, and microdiscectomy is not certified."*

Per reconsideration review dated March 12, 2014, the appeal for bilateral L5-S1 hemilaminotomy, foraminotomy and possible microdiscectomy was denied with the following rationale: "*This patient has had prior surgical requests to include a decompression at L3-L4 and a fusion at L5-S1. The myelogram CT scan on January 15, 2013, showed a left para-midline disc osteophyte at L5-S1, as well as a central disc protrusion herniation at L3-L4. There was a December 13, 2013, MRI with and without contrast that showed no central canal stenosis, but a broad-based left paracentral disc protrusion at L5-S1. The neurological examination suggests L4-L5 and S1 involvement bilaterally. The reflex examination and presence of atrophy are not reported. There was a prior surgery at L4-L5. The request was for reconsideration was non-authorized for bilateral L5-S1 hemilaminotomy, foraminotomy, possible microdiscectomy as not medically necessary."*

ANALYSIS AND EXPLANATION OF THE DECISION INCLUDE CLINICAL BASIS, FINDINGS, AND CONCLUSIONS USED TO SUPPORT THE DECISION:

Laminotomy with decompression nerve root and lumbar additional vertebral space and lumbar laminectomy additional segment would not be considered medically necessary and appropriate based on review of the records and the Official Disability Guidelines. Official Disability Guidelines support discectomy if there are symptoms and physical examination findings which support the diagnosis of radiculopathy, there is concordance between radicular findings on history and physical examination and imaging, and patients fail appropriate conservative care. Guidelines state that electromyography are unequivocal evidence of radiculopathy but are not necessary if radiculopathy is already clinically obvious. In this case, the neurologic examination is non-focal. The electromyography has demonstrated only a left L5 radiculopathy problem. The MRI has failed to demonstrate any significant neurocompressive lesions. Absent convincing documentation of a neurocompressive lesion, opined that the L5-S1 disc protrusion was causing lateral recess stenosis which was likely producing the claimant's symptomatology. The MRI report fails to document lateral recess stenosis. Lateral recess stenosis typically causes neurogenic claudication and not radicular pain. As there is no convincing evidence of a neurocompressive lesion on the MRI, surgery cannot be certified in this case based upon the Official Disability Guidelines.

A DESCRIPTION AND THE SOURCE OF THE SCREENING CRITERIA OR OTHER CLINICAL BASIS USED TO MAKE THE DECISION:

☒ **ODG- OFFICIAL DISABILITY GUIDELINES & TREATMENT GUIDELINES**